Wyoming Cancer
SURVEILLANCE PROGRAM

Spring 2009

The Primary Site is a semi-annual publication of the Wyoming Cancer Surveillance Program (WCSP).

This and previous issues are also available online at:

http://www.health.wyo.gov/phsd/wcsp/news.html

In this issue:

The Primary Site

Follow-up Requests

When receiving either a cherry or purple colored follow-up form requesting any new information, please take the time to fill out the form with as much updated information as possible. If the patient has not been seen in your facility for quite some time please indicate on the follow-up request the patient's primary care physician, or any other physician involved in the case who may still be following the patient. That way, when the WCSP receives the information back from your facility, we will put the newly acquired information into our database. We will then use the new information next time to contact those physicians (who are more likely to be seeing the patient on a regular basis) first, before requesting follow up information from your facility.

Completion of follow-up forms helps the WCSP collect the most up-to-date and accurate information on cancer patients throughout Wyoming to be used in various studies and reported to national agencies.

The Economics of Health

Submitted by: Deb Broomfield

This country is in a recession, and it seems that we have been for a year. Wait a minute, weren't we just told, "This country is NOT in a recession" by all those economy analysts? American households are evaluating their spending habits and adjusting to having less money to spend on food each week. Families are now constantly making conscious decisions about what they can and cannot afford. While all households find this to be a difficult process, it is especially difficult on those who recently moved onto Income Support.

Hard economic times have been experienced in America before. It is too early to analyze current spending habits, so we look to history for trends in health. Our most recent recessions were those in 1974 and 1982 when recovery took most of the 80's. Yes, that's right, the Reagan years (1981-1989) and Reaganomics. The statistics from this period showed an increase in cardio-vascular diseases (CVD), cirrhosis, suicide and an increase in admissions to mental institutions. Statistics also showed a downturn in health prevention and cancer deaths rose twenty-three percent. During hard economic times, work related time commitments increase stress which in turn changes our living habits. Americans buy more pastas, make fewer doctor appointments, skip the exercise and eat fast foods. Currently, there are 46 million Americans without health insurance, 179 million without adequate coverage. Obesity in the United States is rising at an alarming rate. Between the 1960's and 2004, the prevalence of obesity has increased from thirteen to thirty-two percent. A study conducted at The Johns Hopkins Bloomberg School of Public Health predicts that if trends continue, "by 2015, 75% percent of adults and nearly 24 percent f U.S. children and adolescents will be overweight or obese."[1] This study includes data from four national surveys including National Health and Nutrition Examination Survey (NHANES) and Behavioral Risk Factor Surveillance System (BRFSS). In a related study, the Johns Hopkins co-authors found that people purchase foods based on their income level and perception of a food's health/cost benefit. Ethnicity, gender and environmental factors tend to impact people's food choices.

Chain food markets have moved out of the big cities. This in turn makes it difficult for residents in the city to shop at a store that provides adequate choices for a healthy meal. "In a 1993 Study in Eastern Pennsylvania, researchers found that the average full-service supermarket offered 19 kinds of fruit, 29 kinds of vegetables, and 18 kinds of meat, while the average small store only carried 6 kinds of fruit, 5 kinds of vegetables and 2 kinds of meat."[2]There are also an increasing number of dollar and overstock stores opening in the inner cities or at the malls. Food buying becomes a convenience rather than a nutritional choice. The average cost for a family of four to eat a meal at home (chicken breast, baby potatoes, broccoli, whole milk and a fruit cocktail) is $17.52. The total calories: 2188, 109 fat grams and 1134 grams of sodium. A dinner for four at McDonalds (Big Mac, cheeseburger, fries, two Mcnugget Happy Meals with apples and milk) is $13.07. The total calories: 2470, 115 fat grams and 3290 grams of sodium. And that is without the hot apple pies! Not a huge difference, but the home cooked meal is more nutritious and promotes family time so often lacking in a two income home.

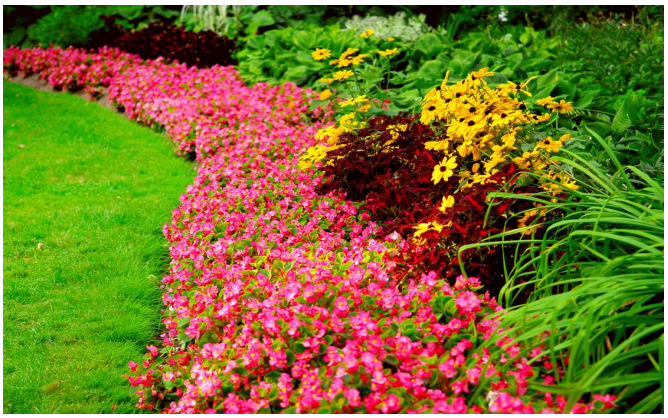
Statistics show us that poor nutrition can lead to CVD, diabetes and cancer. Educating the public on the importance of setting up good nutritional practices in the home the family in the future is the healthier America.

References

[1]http://www.eontarionow.com/index.phps=american+obesity+rates+continue+to+ climb

[2]http://www.preventioninstitute.org/CHI_supermarkets.html

[3]http://www.nytimes.com/2008/10/07/health/07well.html?_r=2&ref=health&oref=slogin



The Fat Attack

Submitted by: Vicki Moxley

Most of the women in my family have carried 20 to 40 extra pounds beyond their recommended weight.

My mother died from complications associated with breast cancer, my maternal aunt died form Non-Hodgkin's Lymphoma, my sister has had bilateral breast cancer, and I have had melanoma. My maternal grandmother was never diagnosed with cancer, but she had an abdominal tumor when she died and she was probably 30 pounds under weight. So are my risks for cancer greater because of my weight or my family genes? This is probably a "no brainer", but do my risks go higher because of my weight?

Due to the technological revolution, our lifestyles have been changing for many years. We are lacking physical activity, but we continue to eat more calories than we use. The percent of obese body mass index (BMI over 30) people is rising. We no longer prepare our own food, but buy it ready made and "nuke" it or grab a quick burger, donut or other fat and calorie laden foods. We expect huge portions on our plates when we go to a restaurant and we consume it all at one sitting. No wonder we are more vulnerable for developing health problems. We do not give our bodies the stimulation that is needed to work properly for our health.

Per the National Cancer Institute (NCI), "increased body weight is related to an elevated risk of mortality from cancer."[1]

Per the World Health Organization (WHO), approximately 30% of cancers in the Western Countries can be associated to dietary factors, making diet, second to tobacco, as a preventable cause of cancer.

There is a "world" of information correlating obesity and the risk of cancer. The articles seem to say the same thing as if many different people wrote their article from the same research project. There are several cancers with an association to body weight or obesity; colon, endometrial, breast, prostate, kidney and gallbladder, esophageal, ovaries and pancreas, depending on which article you read. A 2002 study indicated that approximately 3.2 percent of all new cancer cases could be contributed to obesity.

A diet high in fat content increases the risk of colon, rectal, prostate and endometrial cancer. Diets high in refined carbohydrates and sugar may increase the concentration of growth factors that possibly promote the growth of cancers. Physical activity may reduce the risk of breast and colon cancer.

Research has shown that fat releases extra hormones which may contribute to the risk of breast and endometrial cancer in postmenopausal women. Some studies have shown that the recurrence rate decreases with weight loss following the diagnosis of breast cancer.

Obesity hinders some treatment options. It becomes harder to calculate the amount of chemotherapy and radiation to use.

Nutritionists and exercise enthusiasts keep telling us to decrease our fat intake, eat less red meat, and increase our fiber, fruits and vegetables and to keep physically active. If we follow their recommendations for healthy eating and physical activity, we will lose weight and decrease our risk of developing various cancers and other health problems.

References:

[1]http://www.cancer.gov/newscenter/pressreleases/BMImortality

[2]http://caonline.amcancersoc.org/cgi/reprint/52/2/92

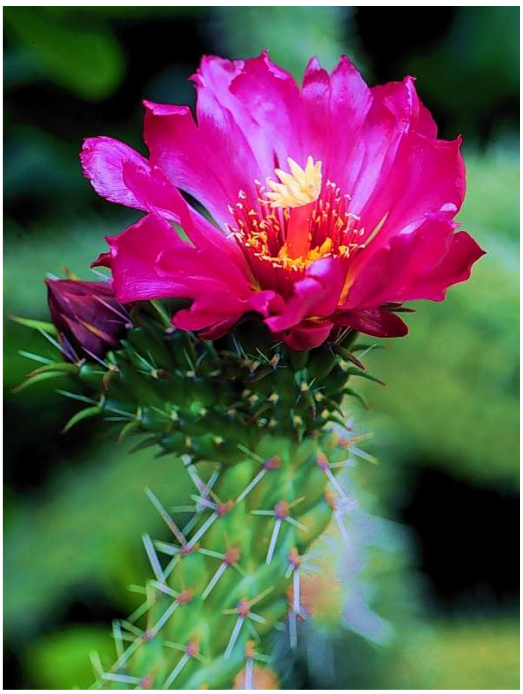
[3]http://www.who.int/dietphysicalactivity/publications/facts/cancer/en/

[4]http://www.cancer.gov/cancertopics/factsheet/Risk/obesity

[5]http://jco.ascopubs.org/cgi/content/full/26/25/4060

[6]http://www.foxnews.com/story/0,2933,200981,00.html

.



Sleuthing for Missing Cases

Submitted by: Deneen Shadakofsky

Where did that cancer case come from? Why didn't we get that one? How do we miss all these? The difference between the guidelines used to ascertain a reportable case for cancer abstraction at the central and hospital approved cancer registries vs. that used by an inpatient or outpatient coder in a hospital setting is interesting. Here's what we found.

Central and Hospital Cancer Registry Guidelines:

Case Eligibility Based on Diagnostic Terms

The American College of Surgeons Commission on Cancer (CoC) requires registries in approved hospital programs to accession, abstract, and conduct follow-up activities for required tumors diagnosed and/or initially treated at the abstracting facility. **The tumors must meet the criteria for analytic cases (classes of case 0, 1, or 2), and pathologically and clinically diagnosed inpatients and outpatients must be included.**

As part of the central cancer and hospital cancer registry case-finding activities, all pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included.

List of Ambiguous Diagnostic Terms	
Terms That Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect (ed)
Compatible with	Suspicious (for)
Consistent with	Tumor** (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm** (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	
Terms That *Do Not* Constitute a Diagnosis *without additional information*	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

**additional terms for non-malignant primary intracranial and central nervous system tumors only.

http://www.facs.org/cancer/coc/fords/2007/fordscorrected0707.pdf

Hospital Coding Guidelines:

According to the **ICD-9 CM** Official Guidelines, effective October 1, 2008; the following are:

1. Guidelines for coding inpatient services of uncertain diagnosis.

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

These guidelines apply only to all non-outpatient settings (acute care, short-term, long-term care; psychiatric hospitals, home health agencies, rehab facilities; nursing homes).

2. Guidelines for coding of outpatient services of uncertain diagnosis

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

List of Ambiguous/Uncertain Diagnostic Terms		
Terms That Constitute a Diagnosis		
Central Registry	**Hospital Inpatient**	**Hospital Outpatient**
Apparent(ly)	Probable	Inconclusive/uncertain diagnostic terms are not used in coding outpatient services and may not be reported as cancer cases to the central registry at the State.
Appears	Suspected	
Comparable with	Likely	
Compatible with	*Questionable	
Consistent with	*Possible	
Favors	*Still to be ruled out	
Malignant appearing	Other similar terms	
Most likely		
Neoplasm (only diagnoses of C70.0–C72.9, C75.1–75.3)		
Presumed		
Probable		
Suspect (ed)		
Suspicious (for)		
Tumor (only diagnoses of C70.0–C72.9, C75.1–75.3)		
Typical of		

*Uncertain (ambiguous) terms not used by central registry at the State to report/abstract cancer cases.

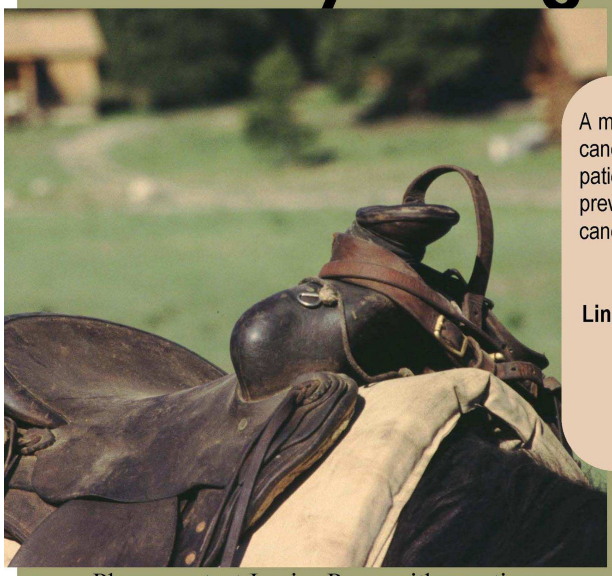
It seems that the main difference for hospitals coding and therefore reporting patient cancer cases to the central and or hospital cancer registries comes from coding guidelines for terms indicating uncertainty. Coding of ambiguous/ uncertain terminology for inpatients has some slight variation from that of the cancer registry. However, outpatient coding of uncertain/ambiguous terminology is not done and therefore, the potential for some cancer cases not being reported to the registry is likely. With more and more procedures being done on a outpatient basis, the number of cases not reported to the registry is likely to increase.

http://www.cdc.gov/nchs/datawh/ftpserv/ftpICD9/icdguide08.pdf

ANNOUNCEMENTS

2009 Wyoming Cancer Conference

Saddle Up For A Cure



A must attend event designed for physicians, healthcare providers, state agencies, cancer control advocates, policymakers, concerned community members, cancer patients, survivors, families, and caregivers. Everyone has a role to play in cancer prevention and control. This conference is designed to offer education about the cancer continuum, ranging from prevention to survivorship.

Speakers Include:

Linda Burhansstipanov, MSPH, DrPH, CHES —Native American Cancer Research Center

Thomas Poulton, MD—Uinta Urology

Lori Benson—Cancer Survivor and Film Director

Kevin Sharp—Cancer Survivor and Country Recording Artist

April 29-30, 2009
Holiday Inn
Sheridan, Wyoming
1(877) 672-4011

Please contact Jessica Perez with questions:
307.777.7362 Jessica.Perez@health.wyo.gov
or visit www.fightcancerwy.com

Wyoming Comprehensive Cancer Control Program

Wyoming Comprehensive Cancer Control Consortium

Wyoming Department of Health

2008-2009 NAACCR WEBINARS

Do you feel like you have to jump through hoops to get cancer registry and cancer surveillance training? Are you looking for training that eliminates travel associated with training and minimizes the time away from your desk? If so, the NAACCR 2008-2009 Cancer Registry and Surveillance Webinar Series is for you.

The 2008-2009 NAACCR webinar series will include twelve webinars, one each month, beginning in October 2008 through September 2009. Six of the twelve webinars will focus on site-specific data collection and will include information on data items required by all standard setters. The subject matter will be pertinent to central and hospital registry staff. The remaining six webinars will focus on other aspects of cancer surveillance and data collection, three of which are pertinent to central and hospital registry staff and three of which are more pertinent to central registry staff. However, place of employment does not restrict participation in any of the webinars.

Go to the NAACCR website, www.naaccr.org, for a registration form and complete schedule. Contact Shannon Vann (svann@naaccr.org, 217-698-0800 ext. 9) or Jim Hofferkamp (jhofferkamp@naaccr.org, 217-698-0800 ext. 5) for answers to your questions about the 2008-2009 webinar series. Please forward this message to your data submitters.

ANNOUNCEMENTS CONTINUED

SAVE THE DATE

North American Association of Central Cancer Registries (NAACCR) 2009 Conference: June 13-20, 2009 San Diego, California - 2010 Quebec City, Quebec, Canada for more information see website www.naaccr.org

National Cancer Registrars Association (NCRA) Educational Conference 2009: May 30 – June 2, 2009 New Orleans - 2010 Conference April 20-23 Palm Springs, California for more information see website www.ncra-usa.org

WY Cancer Surveillance Program

Julia Espinoza, BS, RHIT, CTR , Program Mgr.

Monica Asher-Davis, BS, CTR, Abstractor

Deb Broomfield, BS, CTR, Abstractor

Vicky Moxley, BS,CTR, Abstractor

Deneen Shadakofsky, Abstractor

Eunice Schleicher, Administrative Assistant

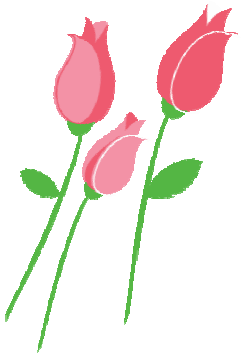
Ginger Anderson, Follow-up Specialist

Main Number:
307-777-7951 or 1-800-456-5847 Option #3
FAX: 307-777-3419

Please visit us

The WCSP is located at the Wyoming Department of Health within the Preventive Health and Safety Division:

http://www.health.wyo.gov/PHSD/wcsp/index.html



"We acknowledge the Centers for Disease Control and Prevention for its support of the Wyoming Cancer Surveillance Program, and the printing and distribution of 'The Primary Site' under cooperative agreement CDC-DP07-703000801-02 awarded to the Wyoming Cancer Surveillance Program. The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention").